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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

February 4, 2011

TO: Each Supervisor

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **AMBULATORY CARE WORK PLAN**
(Agenda Item #36 for February 8, 2011 Board Meeting)

Attached please find the Department of Health Services (DHS) Ambulatory Care Restructuring Work Plan, which is being provided as supplementary information to the December 22, 2010 Chief Executive Office memo on Negotiations with L.A. Care and DHS Ambulatory Care Restructuring.

The Work Plan briefly summarizes key ambulatory care issues faced by the Department, important deadlines related to implementation of the new 1115 Waiver, and planned action steps and target dates to address those issues.

The work plan was last updated on January 26, 2011, and we are in the process making additional updates as relevant information changes. My team and I have already implemented first steps in this plan and will provide you with regular reports as progress on the plan proceeds.

Please contact me with any questions or feedback.

MK:ws

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

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January 26, 2011

Mitchell H. Katz, M.D.
Director

DHS Ambulatory Restructuring

Problem

The current ambulatory system in DHS is inadequate to meet the demands of the waiver or the requirements under health reform. In particular, we have insufficient capacity, inadequate timeliness for services, and do not have in place the necessary contractual relations with LA Care or with community providers to develop a robust system. We do not have the appropriate IT systems to coordinate care (e.g., registry, referral system). We do not have an organizational structure for ambulatory care.

Key Deadlines:

June 1, 2011

Special population patients (SPDs) move from fee-for-service Medicaid to managed care Medicaid. There are approximately 27,600 such patients in the DHS system receiving full spectrum services (primary, specialty, and hospitalization) and an additional 3,700 patients receiving care at community clinics. SPDs come with very challenging standards of accessibility and timeliness.

April 1, 2011

Healthy Way LA expansion. Opportunity to obtain 50% match for expenses. Currently 55,000 persons in program need to be transitioned. Goal enroll 130,000. By enrolling people into Healthy Way LA we will capture Federal dollars for patients we have traditionally cared for at 100% County expense. Program comes with very challenging standards of accessibility and timeliness.

How we are going to meet deadlines/requirements?

A. Structure

1) Switched from a group process to a project focus.

2) Appoint Interim CMO for Ambulatory Care – Nina Park, M.D.

3) Completed position specifications for Ambulatory Care Director; in the recruitment process.

4) Established work group with LA Care and County Counsel to resolve contract issues to bring to Board for approval.

5) Established work group with community clinics to resolve contractual issues to bring to the Board.

B. Develop relationship between LA Care and DHS for managed care.

1) County legal review and approval of LA Care professional and ancillary provider contract templates for SPDs

2) Determine functions that DHS will perform and those LA Care will perform (March 2011)

C. CHP Transition

1) Independent financial audit of CHP completed. Proprietary information is being redacted. Transmittal letter to Board of Supervisors in 2 weeks.

2) Complete negotiations on an agreement to transfer the current Medi-Cal managed care population from CHP to L.A. Care (May 2011)

3) Implementation and transition of current CHP Medi-Cal membership to L.A. Care (late calendar year 2011)

D. Institute a process for DHS inter-department planning and integration with Mental Health and Public Health

1) Establish priorities for integration between Departments, with particular focus given to the implications of the Waiver and Health Reform. (1/24/11)

2) Secure CEO agreement of inter-Department priorities. (2/7/11)

3) Establish work plan for the implementation of priorities. (2/14/11)

4) Implement at least two pilots for integrated services. (6/1/11)

5) Complete data matching with DMH and DPH to identify priority populations for HWLA enrollment. (2/7/11)

6) Establish enrollment processes for priority HWLA patients. (2/21/11)

7) Establish referral processes for HWLA patients with dual health needs. (2/21/11)

8) Establish care coordination and data sharing protocols for HWLA patients with dual diagnoses. (2/21/11)

9) Develop concept of behavioral health mental homes and approach PPPs regarding provision of primary care.

10) Implement Tier 2 services for HWLA patients in DHS CHCs and MACCs.

E. Implementation of Medical Homes within DHS. (6/1/11)

1) Empanel patients within DHS medical homes: (7/1/11)

a. i. pilots: construct a baseline panel of current patients within DHS PCMHs. (1/17/11)

a. ii. pilots: implement a baseline panel of current patients within DHS PCMHs. (2/21/11)

a. iii. system: construct a baseline panel of current patients within DHS PCMHs. (2/21/11)

a.iv. system: implement a baseline panel of current patients within DHS PCMHs. (3/1/11)

b. determine panel size criteria based on PCMH provider staffing. (3/7/11)

c. determine capacity of all DHS PCMHs to accept SPD and HWLA assignments. (3/7/11)

d1. pilots: design a panel management system that is able to assign a complexity weight to new patients, includes a mechanism to open and close panels, and is able to reassign patients to other primary care teams when necessary (provider no longer available due to resignation, reduction of time, illness). (4/1/11)

d2. system: design a panel management system that is able to assign a complexity weight to new patients, includes a mechanism to open and close panels, and is able to reassign patients to other primary care teams when necessary (provider no longer available due to resignation, reduction of time, illness) (7/1/11)

e1. Pilots: provide training on panel management for administrative support units (pilots March; spread to all Medical Homes within DHS system July). (2/28/11)

e2. System: provide training on panel management for administrative support units (pilots March; spread to all Medical Homes within DHS system July). (7/1/11)

f. design a central support, monitoring and reporting system based on PCMH panels to enable reports to be developed. (7/1/11)

g1. reports available on panel sizes (pilots March; system May) (3/1/11)

g2. reports available on panel sizes (pilots March; system May) (5/1/11)

h. reports available on panel health outcomes (waiver based) (pilots July, pilot facility, region and system to follow). (7/1/11)

2) Use a registry to deliver care in DHS medical homes. (3/1/11)

a. Phase 1: implement subset of tasks/rules already in CRM registry for PCMH pilots. (2/14/11)

i. assign roles to medical home team members (January) (1/24/11)

ii. develop sample workflows (January) (1/24/11)

iii. orient and train medical home team members in use of registry (January) (1/24/11)

iv. conduct site visits to refine workflows in each site (January - February) (2/7/11)

b. Phase 2: develop new, high yield, task lists for registry for PCMHs which includes: (5/2/11)

i. create auto-filled fields in the registry for (1) admission to hospital (2) discharge from the hospital (3) ER visits (4) Outpatient visits to the medical home provider (March) (3/7/11)

ii. create auto-filled fields for select laboratory values (March) (3/7/11)

iii. create the ability to assign tasks to particular roles within the medical home teams (March) (3/7/11)

iv. create a day-of-care plan that supports patient visits (May) (5/2/11)

v. Create the initial rule set for care coordination and care management (February) (2/7/11)

vi1. support registry use by ensuring (1) functional hardware (2) adequate bandwidth (3) training on use of the registry (4) user support infrastructure including help line (pilots – February; system - July) (2/7/11)

vi2. support registry use by ensuring (1) functional hardware (2) adequate bandwidth (3) training on use of the registry (4) user support infrastructure including help line (pilots – February; system - July) (2/7/11)

c. Phase 3: Create advanced care management rules for ensuring high quality, lower cost care (12/5/11)

i. ensure availability of auto-filled data for the following: select medication data, outpatient blood pressure readings, immunization administration (influenza and pneumovax), PPD status, schedule data (for reminder calls and planning care) (9/5/11)

ii. create documentation support and decision support for common diagnoses (there is a current prototype for asthma) (September) (9/5/11)

iii. use interactive voice recognition to perform reminder tasks and clinical questionnaires (December) (12/5/11)

iv. accomplish full panel management in registry by creating bi-directional data communication with the data warehouse (December) (12/5/11)

3) Care Management

a. develop overall care management program description/plan (January) (1/24/11)

b. develop duty statement for care manager (January) (1/24/11)

c. develop duty statement for care coordinator/s (January) (1/24/11)

d. determine staffing level for care management program within PCMHs (February) (2/7/11)

e. collect or construct method/s to identify patients at highest risk who offer the greatest potential for improvement in health outcomes (February) (2/7/11)

f. complete a process that results in the ability to use individualized care plans, based on risk score, for patients in the PCMH that
i. uses registry task lists, is built on clinical pathways (March) (3/1/11)"
f. complete a process that results in the ability to use individualized care plans, based on risk score, for patients in the PCMH that
ii. includes standing orders. (June) (6/1/11)"

g. define minimum care management intervention set for high risk/high frequency conditions for SPDs; define acuity tiers and the use of these tiers in care management. (April.) (4/4/11)

h. design a follow up procedures for post-hospitalization, post-emergency room, (March) and post procedural care (September) (3/1/11)

h. design and implement a follow up procedures for post-hospitalization, post-emergency room, (March) and post procedural care (September) (9/5/11)

i. develop and implement training curriculum to prepare care managers for their role/function (pilots, Feb-March; System, June-July) (3/1/11)

i. develop and implement training curriculum to prepare care managers for their role/function (pilots, Feb-March; System, June-July) (7/1/11)

4) Specialty Medical Homes Implemented (7/1/11)

a. determine complexity weight of patients seen at Rancho Los Amigos Spinal Cord Outpatient Center (January) (1/24/11)

b. add one FTE Internist to Outpatient Primary Care Team (January) (1/24/11)

c. define role of Nurse Practitioners as direct providers/Care Managers (February) (2/7/11)

d. define in-clinic non primary care staff for Behavioral health, Rehabilitation and Urology (February) (2/7/11)

e. define and provide minimum primary care elements for clinic including access by phone or urgent care, space, equipment adequate for primary care, ability to manage common chronic illness, initial standards for referral to subspecialists (March) (3/1/11)

f. define unique needs of spinal cord patients that can be provided in a primary care setting (March) (3/1/11)

g. provide training to Internist and NPs in care of spinal cord patients (April-July) (7/1/11)

h. construct and implement a Registry Task List for the Spinal Cord Specialty Medical Home (April) (4/4/11)

i. extend registry use to spinal cord patients

i. Initial use of current registry (March) (3/1/11)"

i. extend registry use to spinal cord patients
ii. Spinal Cord patient specific (May) (5/2/11)

j. develop overall care management program description/plan (including assessment interventions, care plans, roles of team and staffing) (March) (4/7/11)

5) Define role of health educators/health education assistants in medical home model

F. Web-based Electronic Referral System Implemented (7/1/11)

1) Uniform Processes: implement uniform referral processes throughout all DHS regions. (end of March) (Is this same as G.6. below?) (3/28/11)

2.a.) E-Referral System Criteria: develop criteria for a DHS-wide E-Referral System, including:

- Capability of sending referral results back to the Medical Home for care coordination.
- Coordination of behavioral / DMH referrals. (Referral Team) (1/17/11)

2.b.) E-Referral System Criteria: survey other e-referrals used in other large USA health care systems and identify existing e-referral systems that meet criteria (end of January) (1/24/11)

3) Identify System: identify or create e-referral system for use in DHS (May) (5/2/11)

4) Implement e-referral system with auto-review capabilities for use in top 10 specialties (July) (7/11/11)

G. Specialty Clinic Capacity

1) HWLA Appointment Slots: Implement reservation of specialty care appointment slots for HWLA members to ensure that MCE access standards are met. (2/7/11)

2) Specialty Clinic Capacity: audit existing specialty clinic capacity in DHS rooms, providers, sessions, visits, productivity, sites. (1/24/11)

3) Determine Needed Specialty Capacity: calculate needed specialty capacity and identify gaps for the SPD and HWLA patients for whom DHS will have responsibility. Identify top 10 specialties needed by these populations and all mandatory criteria and expectation for access to specialty consultation for managed care patients. (1/25/11)

4) Specialty Utilization: identify current specialty utilization by patient origin and clinical site. (1/25/11)

5) Specialty Care "Decompression": audit select specialty clinical services for "hidden" capacity (provider productivity, dischargeable patients, restricted meds, inappropriate referrals), focusing on specialties most needed by SPDs and HWLA patients and make recommendations on targets for "decompression" to partner primary care clinics—PPPs and DHS facilities--and policy changes for specialty referrals. (2/7/11)

6) Begin Implementation of standardized policies and processes based on opportunities identified in G.5. (3/28/11)

7) Current Best Practice Innovations: identify existing best practice innovations in DHS designed to enhance specialty capacity, targeting the most effective for meeting specialty requirements contained in the Waiver (end of February) and spread targeted innovation pilots to enhance specialty access to other DHS sites (March) (3/7/11)

8) Additional Best Practice Innovations: identify additional innovative methods and processes to enhance specialty care access (e.g. telemedicine, e-consultation, champions, enhanced medical homes, DHS-wide referrals, expansion of specialty care in CHCs, etc.) (March) (3/7/11)

9) Decompress Specialty Clinics: decompress targeted specialty clinics by 10 percent through redirection to primary care and through change in referral processes (end of June) (6/27/11)